

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013331	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER WATERFORD AT EDISON LAKES, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 PARK PLACE MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: October 2 and 3, 2014</p> <p>Facility number: 013331 Provider number: 013331 AIM number: N/A</p> <p>Survey Team: Shauna Carlson, RN - TC Julie Baumgartner, RN Pamela Williams, RN</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Residential sample: 5</p> <p>Waterford at Edison Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the Initial State Residential Licensure Survey.</p> <p>Quality Review completed on October 10, 2014, by Brenda Meredith, R.N.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE